Manuel To Health
Naturopathic Centre

OFFICE POLICIES

Manuel To Health Naturopathic Centre (M2HNC) has established the following policies in order to ensure the most efficient service to our clients:

- We require a minimum **24 hour notice** for all appointment cancellations or changes. Please leave messages on our answering machine during off-hours.
- For all missed appointments without notification, there may be a charge for the appointment.
- When you arrive late for your appointment, only the balance of the time that was booked for you can be used.
- M2HNC has a **SCENT-FREE** policy. Scents include smells or odours from cosmetics (i.e. perfume, shampoo, make-up etc.) or from other products like air fresheners, cleaning products, etc. These scents may affect other clients' health, especially those with environmental sensitivities.
- Clients **must turn off** all electronic devices during their visits (i.e. cell phone, pagers etc.).
- Full payment is made at the time of your visit, unless prior arrangement has been made with Manuel To Health Naturopathic Centre. Acceptable tenders for transactions are Cash, Cheque, Debit, Visa, or Mastercard.
- The fee for each **NSF** Cheque is $45.
- M2HNC must authorize all product returns.
- Returns must be made with the original receipt **within 14 days** for **credit only** on account. No cash, cheque or credit card refunds will be issued.
- Opened, damaged, or expired products **will not** be accepted for credit.

STATEMENT OF ACKNOWLEDGEMENT AND INFORMED CONSENT

Manuel To Health Naturopathic Centre (M2HNC) is an office with Naturopathic Doctors providing naturopathic health care. Naturopathic Medicine uses non-invasive techniques for the assessment of each client's health and provides natural therapies for treatment.

M2HNC uses Functional Biometry, such as Meridian Stress Assessment System (MSAS) testing and metabolic urine testing, with structural, nutritional, and lifestyle techniques in the assessment of each client. Some of these techniques are considered non-diagnostic, and hence, does not diagnose, treat, prescribe or cure any disease. The purpose of these techniques are to assist in the overall assessment of the client in order to provide optimal quality care to all clients.

There are some health risks associated with naturopathic medicine treatment. These include, but are not limited to:

- Pain, bruising or injury from acupuncture or injections.
- Homeopathic remedies may occasionally result in aggravation of pre-existing symptoms. The duration is usually short when this occurs.
- Some clients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you have.
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

Each client must sign this document before any treatment is rendered. Your signature acknowledges and consents to the following:

1. You understand that the ultimate responsibility of your health is your own.
2. The clinic does not guarantee treatment results.
3. The Naturopathic Scope of Practice will be used.
4. You understand that the treatments provided and/or referred to other health practitioners is based upon the assessment of conditions revealed via your personal history and interview, physical assessment, laboratory testing, and methods used to evaluate the energetic status of the body.
5. You understand that the practice of Functional Biometry, such as Meridian Stress Assessment System Testing, is at this time, considered non-standard and experimental.
6. Failure to follow sound nutritional, exercise and lifestyle programs can undermine the expected results.
7. You are free to withdraw consent and to discontinue treatment at any time.
8. You accept full responsibility for any fees incurred during care and treatment at the time of visit unless prior arrangement has been made with M2HNC.
9. A minimum of 24 hours notice is required for appointment cancellations and changes. Otherwise, you may be billed for missed appointments.
10. Naturopathic Medicine and Conventional Medical Treatment are not mutually exclusive and you have been given the option to continue seeking conventional medical treatment.
11. It is your responsibility to determine whether your health insurance covers Naturopathic Medicine services, treatments, and prescribed natural health products. M2HNC will charge a fee by time for extra paperwork required for uncertain claims for reimbursement.

I, _____ (Print name), have read, understood, acknowledge, and consent to the above statements.

Signed this _____DAY of _____, 20____, at _____ (City/Town), _____(Province), _____(Country)

Signature:_____(Client, Parent or Guardian)

Manuel To Health
Naturopathic Centre

NATUROPATHIC INTAKE FORM – PEDIATRIC

Section 1: Child's Personal Information: Date of Birth (DD/MM/YYYY): ____/____/____

Child's First Name: _____ Middle Name: _____ Last Name:_____

Address: _____ City/Town: _____ Province: _____

Postal code: _____ Home Phone: _____ Cell Phone: _____

Height: _____cm / in Weight: _____ lbs / kg Age: _____ Sex: M F (Circle)

Who is filling out the form (name and relation)? _____

People child lives with: _____

How did you learn about our clinic? Relative____ Friend ____ Professional _____

Name: _____

List of other Health Practitioners you are currently seeing or have seen in the past: (i.e. Types: Family doctor, Specialist doctor, Chiropractor, Acupuncturist, Massage Therapist, Physiotherapist etc.)

_____

_____

_____

Section 2: Child's Parent / Guardian Contact Information:

Name: _____ Relationship to child: _____

Address (If different from above):_____

City/Town: _____ Province: _____ Postal code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

E-mail: _____

Name: _____ Relationship to child: _____

Address (If different from above): _____

City/Town: _____ Province: _____ Postal code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

E-mail: _____

Section 3: Child's Medical History:

Rate your child's general state of health: Excellent Good Fair Poor (circle)

List the health concerns of your child in order of importance, detailing duration of concern and any provided treatments:

1. _____
2. _____
3. _____
4. _____

List previous hospitalizations, surgeries, serious illnesses, and conditions (include approximate dates):

Date	Hospitalizations/Surgeries/Major Illnesses
_____	_____
_____	_____
_____	_____
_____	_____

Check illnesses your child has had (include age):

- ❑ Chicken pox _____
- ❑ Measles _____
- ❑ Rubella _____
- ❑ Mumps _____
- ❑ Fifth disease (Erythema infectiosum) _____
- ❑ Scarlet fever _____
- ❑ Strep throat _____
- ❑ Whooping cough ____
- ❑ Impetigo _____
- ❑ Mononucleosis _____
- ❑ Roseola _____

List **current** medications your child is taking with dates and duration of use (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.): _____
_____
_____

List **past** medications your child has taken with dates and duration of use (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.): _____
_____
_____

State the number of times your child has used antibiotic treatment: _____

Is your child up-to-date on his/her immunization schedule? (circle) Yes / No

Indicate and describe any immunizations that have caused adverse reactions in your child:
_____
_____

List your child's allergies (medicines, food, animals, herbs, environmental, etc.):
_____
_____
_____

List screening tests your child has had, including dates and results (vision, hearing, blood, academic, etc.): _____
_____

Section 4: Child's Pre-natal History:

What was the health of the parents at conception?

Mother: Poor / Fair / Good / Excellent / Unknown (circle)

Father: Poor / Fair / Good / Excellent / Unknown (circle)

What was the health of the mother during the pregnancy? (circle) Poor / Fair / Good / Excellent / Unknown

What was the mother's age at child's birth? _____

Indicate any complications **during pregnancy**:

- ❑ Gestational diabetes
- ❑ Toxemia
- ❑ Pre-eclampsia (High blood pressure)
- ❑ Hemorrhaging (Bleeding)
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Thyroid problems
- ❑ Trauma (mental, emotional, physical, etc.)
- ❑ Required bedrest
- ❑ Other: _____

Indicate mother's use of any of the following **during pregnancy**:

- ❑ Tobacco
- ❑ Alcohol
- ❑ Prescription medications
- ❑ Recreational drugs
- ❑ Over-the-counter medications
- ❑ Supplements _____
- ❑ Other: _____

List any environmental exposures during the pregnancy (paint, silver amalgams, new carpet, pets, cigarette smoke, etc.): _____
_____
_____

Section 5: Labour and Delivery of Child:

Term length (in weeks): _____ Labour length: _____
Place of birth (city, province): _____ Site of birth (home, hospital, etc.): _____
Adopted: _____ If yes, at what age? _____
Type of birth and devices used if applicable: Vaginal / C-section / Induced / Forceps / Epidural / Vacuum / Other _____
List health-care providers whose services were rendered during pregnancy: OBGYN / Midwife / Doula / GP / Other _____

Section 6: Child's Neonatal History:

Birth weight: _____ Birth length/height: _____

Describe any complications at, or shortly after, birth:

- ❑ Jaundice
- ❑ Respiratory difficulties
- ❑ Rashes
- ❑ Seizures
- ❑ Failure to thrive
- ❑ Birth defects:_____
- ❑ Blood sugar concerns
- ❑ Birth injuries: _____
- ❑ Other:_____

Section 7: Child's Diet:

Breast-feeding: Yes No (circle) If yes, for how long? _____
List problems encountered during breastfeeding (breast tenderness, insufficient milk supply, difficulty latching, disinterest, infection, etc.): _____
_____
Formula: Yes No (circle) If yes, what kind of formula (milk/soy/other)? _____
List dietary restrictions (religious, vegan, vegetarian, etc.): _____
Describe a typical day's diet with quantities:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
List favourite foods: _____
List least favourite foods: _____
Beverages (Quantity per day): Soft drinks ____ Milk ____ Juice ____ Water ____ Other: _____

Section 8: Child's Health and Development:

SLEEP:
Number of hours of sleep _____

Difficulty falling asleep?	o Yes	o No		
Wake up rested?	o Yes	o No		
Wake in middle of the night	o Yes	o No	What time? _____	
Recall dreaming?	o Yes	o No		
Recurrent dreams?	o Yes	o No		
Take naps?	o Yes	o No	When? _____	How long? _____

ENERGY:
Rate your energy level (circle): 1(very low) -----2-----3-----4-----5-----6-----7-----8-----9-----10 (high)
Best energy time? _____ Lowest energy time? _____

Section 9: Child's Environment:

Describe your child's temperament: _____
Does your child currently attend? (circle) School / Daycare / Homecare / Other: _____
Describe your child's behaviour and performance at the above location:

_____
Describe how well your child interacts with others (siblings, children, adults, etc.):

_____
List any toxins or hazards to which your child is exposed to (smoking, pesticides, pets, cleaning products, etc.): _____

_____
List and describe your child's favourite hobbies/activities: _____

_____
List your child's anxieties, fears, and phobias: _____

Section 10: Child's Family History:

Please indicate (with a check) all family medical history, and list their relationship to the child (mother, father, brother, sister, aunts/uncles, grandparents, etc.) for:

__Diabetes_____ __Allergies_____
__Cancer_____ __Asthma_____
__Heart Problem_____ __Thyroid Problem_____
__High Blood Pressure_____ __Kidney Disease_____
__High Cholesterol_____ __Mental Disorder_____
__Genetic Defect_____ __Drug/Alcoholism_____
__Other_____

Section 11: Review of Systems:

Please check any of the following symptoms which your child experiences:

SKIN, HAIR, NAILS:

o Acne	o Oily skin	o Scaly lesions	o Falling/thinning hair
o Itching	o Bruise easily	o Weepy lesion	o Foot odour
o Rash	o Boils	o Edema (swelling)	o Nail fungus
o Redness	o Hives	o Dry hair	
o Dry skin	o Peeling		

List main areas involved:_____

HEADACHE: Do you have any headaches? o Yes o No
If yes, please describe the pain, location and intensity:

o Dull	o Pressure	o Comes and goes	o Back of head
o Achy	o Band-like	o On the right side	o Forehead
o Heavy	o Dizziness	o On the left side	o Temple
o Sharp	o Constricting	o Top of the head	o Upper teeth
o Burning	o Pulsating	o Behind the eyes	o Mild
o Throbbing	o Constant	o Between eyes	o Excruciating

Anything that makes the headache feel better? _____
Anything that makes the headache worse? _____
Do you feel any associated pain with the headache? o Yes o No
If yes, where? _____

EYES:

- o Itchy
- o Red
- o Dry
- o Swollen
- o Bloodshot
- o Burning
- o Watering
- o Styes
- o Pain
- o Dark circles
- o "Floaters"
- o Blurry vision
- o Wear glasses and/or contacts
- o Far-sighted
- o Near-sighted
- o Twitchy lid
- o Crusty lid
- o Sensitive to light
- o Loss of sight

EARS:

- o Hearing loss
- o Itchy
- o Pressure
- o Dizziness
- o Excessive ear wax
- o Tubes in ears
- o Plugged ears
- o Pain
- o Frequent infections
- o Ringing
- o Fluid inside
- o Other: _____

NOSE/SINUS:

- o Itchy
- o Runny
- o Burns
- o Bleeds
- o Blocked
- o Yellow mucus
- o Blood-streaked mucus
- o Polyps
- o Deviated septum
- o Loss of smell
- o Sneezing
- o Post nasal drip
- o Sinus infection
- o Other_____

When do the symptoms occur? o Spring o Summer o Winter o Fall o All year o Night o Other

MOUTH:

- o Chapped lips
- o Cankers
- o Cracked lips/corner
- o Grind teeth
- o Gum problems
- o Itchy mouth
- o Sore tongue
- o Swollen tongue
- o Bad breath
- o Altered taste
- o Bad taste
- o Teeth pain
- o Fillings, which type? _____

Do you have amalgam fillings? o Yes o No If yes, how many? _____

THROAT:

- o Itchy throat
- o Throat clearing
- o Pain
- o Loss voice
- o Hoarse voice
- o Sore throat
- o Difficulty swallowing
- o Throat closes
- o Swollen neck glands
- o Other_____

HEART/CIRCULATION:

- o Palpitations/racing heart
- o Skipped beats
- o Murmur
- o Tingling
- o Chest pain
- o High blood pressure
- o Blue lips
- o Ankle swelling
- o Bleeding tendency
- o Rheumatic fever
- o Congenital defects
- o Heart disease
- o Numbness
- o Anemia
- o Bruise easily
- o Leg cramps
- o Cold hands/feet
- o Deep leg pain
- o Blood type _____
- o Other _____

RESPIRATORY:

- o Difficulty breathing
- o Cough – dry
- o Cough – mucus
- o Wheezing
- o Asthma
- o Bronchitis
- o Pneumonia
- o Emphysema
- o Fluid in lungs
- o Heavy chest
- o Tight chest
- o Croup
- o Short of breath
- o Spitting blood
- o Lesions on chest
- o Other_____

GASTROINTESTINAL:

- o Bloating
- o Heartburn
- o Good/poor appetite
- o Indigestion
- o Flatulence
- o Nausea
- o Vomiting
- o Cramping
- o Picky eater
- o Ulcer
- o Hernia
- o Vomit blood
- o Belching
- o Stomach ache
- o Anal itch
- o Hemorrhoids
- o Liver disease
- o Gallbladder disease
- o Diarrhea
- o Constipation
- o Laxative use
- o Pain _____

How often do you have a bowel movement? _____

Describe your stool:

- o Tarry stool
- o Mucus in stool
- o Bloody stool
- o Colour_____
- o Undigested food

URINARY:

- o Bedwetting
- o Kidney disease
- o Bladder disease
- o Urgency
- o Painful urination
- o Burning
- o Increased frequency
- o Blood in urine
- o Difficult urination
- o Discharge
- o Frequent infections

MALE REPRODUCTIVE: (Boys Only)

- o Infection
- o Sores/Lesions
- o Hernia
- o Discharge
- o Lumps
- o Pain _____
- o Other _____

FEMALE REPRODUCTIVE: (Females Only)

- o Sore breasts
- o Vaginal discharge
- o Vaginal burning
- o Vaginal itching
- o Other_____

Menstruation started? o Yes o No If yes, age _____

MUSCULOSKELETAL:

Do you have muscle pain? o Yes o No If yes, where? _____

Do you have joint pain? o Yes o No If yes, where? _____

Have you ever had broken bones? o Yes o No If yes, where? _____

Please check symptoms which apply:

- o Limited movement
- o Morning stiffness
- o Leg cramps
- o Muscle weakness
- o Tingling hand/feet
- o Gait changes
- o Muscle spasm
- o Numbness
- o Dropping objects

NEUROLOGICAL:

- o Seizures or convulsions
- o Tics
- o Fainting
- o Double vision
- o Blurred vision
- o Numbness
- o Paralysis
- o Tingling
- o Lack of coordination
- o Loss of balance
- o Loss of sensation
- o Neurological disorder
- o Other _____

ENDOCRINE:

- o Overactive thyroid
- o Underactive thyroid
- o Other _____
- o Lack of appetite
- o Excessive thirst
- o Hypoglycemia
- o Diabetes
- o Increase in appetite
- o Weight gain
- o Weight loss
- o Excessive sweating
- o Hot/Cold intolerances

PSYCHOLOGICAL:

o Mood swings	o Anger/Aggressive	o Grief	o Clumsy
o Depression	o Joy	o Fear	o Hyperactive
o Anxiety	o Sad	o Feel groggy	o Short attention span
o Forgetful	o Worry	o Restless legs	
o Other _____			

ENVIRONMENT:

What type of housing do you live in? o House o Mobile home o Apartment/Condo o Work camp o Farmhouse o Other_____

How long have you lived there? _____

Is there any room(s) in your home which may cause you to experience symptoms? o Yes o No If yes, where? _____ _____

Is there a mold? o Yes o No

Is it quite dusty? o Yes o No

Is there a lot of vegetation around? o Yes o No

Do you live near a power generation station? o Yes o No If yes, how near? _____

Do you live near transmission lines or a power transformer? o Yes o No If yes, how near? _____

Do you live near a communication tower? o Yes o No If yes, how near? _____

What type of water do you drink? o Tap water o Well water o Reverse Osmosis o Brita filter o Bottled water - Brand:_____

Do you use an air purifier? o Yes o No

Is there anything else that you feel is important that has not been covered?

_____
_____
_____
_____

Thank-you for completing the intake form

Manuel To Health
Naturopathic Centre

PATIENT CONSENT FORM
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Liona Manuel B.Sc. ND acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopathic Doctors of Alberta (CNDA).

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our Clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

This Clinic will collect, use and disclose information about you for the following purposes:

- to assess your health concerns
- to provide health care
- to advise you of treatment options
- to establish and maintain contact with you
- to send you newsletters and other information mailings
- to remind you of upcoming appointments

- to communicate with other treating health-care providers
- to allow us to efficiently follow-up for treatment, care and billing
- to complete claims for insurance purposes
- to comply with legal and regulatory requirements of our regulatory body, the College of Naturopathic Doctors of Alberta, acting under the authority of Alberta's *Health Professions Act*.
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this clinic to comply with all regulatory requirements
- to comply generally with the law
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that *Manuel To Health Naturopathic Centre* can collect, use and disclose personal information about _____ as set out above in the information about the clinic's privacy policies.
(Patient's name)

_____ _____
Parent/Guardian Signature Print name

_____ _____
Date Signature of witness

Manuel To Health
Naturopathic Centre

PRIVACY POLICY

We, at Manuel To Health Naturopathic Centre are committed to collecting, using and disclosing personal information in a responsible manner, and only to the extent that is necessary for the services we provide. We will be open with our handling of your information, as you will see from this Privacy Policy.

Please note that in this document, patient and client are considered to be interchangeable terms.

What is personal information?

Personal information refers to any information that can identify an individual. Personal information that we collect **may** include:

- Name, address, telephone number, fax number, e-mail address, date of birth, social insurance number, occupation, name of employer, place of employment, insurance company, insurance coverage
- Education, gender, sexual orientation, ethnicity, health history, health records, family history, hours of work, income
- Activities or views e.g. religion, politics, opinions, community involvement

Information related to a person's business is not protected by privacy legislation.

Collecting Personal Information:

Primary Purposes: For our clients, the primary purpose for collecting personal information is to help us assess what your health concerns are, to advise you of your options, to provide the health care you desire and to establish and maintain contact with you.

Related purposes: For our clients, related purposes for collecting personal information include: invoicing and statements, accounting and tax records, follow up services, quality control, communication with other health care providers, insurance claims, education (e.g. newsletters/articles, seminar announcements), marketing and compliance with regulation by a licensing/regulatory body. You can choose not to be part of some of these related purposes; for example, declining seminar announcements or newsletters. Please be aware that it may not be possible to decline some of the related purposes, such as information required by a regulatory body.

For members of the general public (non-clients), our primary purpose for collecting personal information is to allow the practitioners or staff to follow up on inquiries, ensure your request was properly handled (quality control), and provide information updates if you have expressed interest in receiving such notices.

For contract staff, our primary purpose for collecting personal information includes: communications, client communication, accounting and tax records, quality control, and education.

Protecting Personal Information:

We understand the importance of protecting personal information. For that reason, we have taken steps to safeguard your personal information from unauthorized access, disclosure, use or tampering.

Safeguards are in place to protect your personal information against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.

Your personal information is protected, whether it is recorded on paper or electronically.

Practitioners and staff are trained to collect, use and disclose personal information only as necessary to fulfill their duties and in accordance with our Privacy Policy.

Retention and Destruction of Personal Information:

Client files (containing personal information) will be maintained for a minimum of seven years.

Care is exercised in the destruction of personal information to prevent unauthorized access to the information even during disposal and destruction.

Accuracy of Personal Information:

This clinic endeavours to ensure that your personal information is as accurate, complete, and as up-to-date as necessary for the purposes that it is to be used.

Information shall be sufficiently accurate, complete and up-to-date to minimize the possibility that inappropriate information is used to make a decision about you as our patient.

With only a few exceptions, you have the right to see what personal information we hold about you.

If you believe there is a mistake in the information, you have the right to ask for it to be corrected. This applies to factual information and not to any professional opinions we may have formed.

Consent:

This clinic will seek informed consent for the collection, use and/or disclosure of personal information, except where it might be inappropriate to obtain your consent, and subject to some exceptions set out in law.

Consent is required for the collection of personal information and subsequent use or disclosure of that information. In order for the principles of consent to be satisfied, our clinic has undertaken reasonable efforts to ensure that you are advised of the purposes for which information is being used, and that you understand those purposes. Once consent is obtained, we do not need to seek your consent again, unless the use, purpose or disclosure changes.

Consent for the collection, use and disclosure of personal information may be given in a number of ways, such as:

- signed medical history form;
- signed introductory questionnaire;
- taken verbally over the telephone and then charted;
- e-mail;
- written correspondence

You may withdraw consent upon reasonable notice.

Do You Have a Concern?

Our information Officer is Liona Manuel B.Sc. ND, who can be reached at 587-280-9888 or via email at liona.manuel@m2hnc.ca to address any questions or concerns you may have.

If you wish to make a formal complaint about our privacy practices, you may make it in writing to our Information Officer. She will acknowledge receipt of your complaint, ensure that it is investigated promptly, and that you are provided with a formal decision and reasons in writing.

Thank you for your interest in our Privacy Policy. If you have a concern about the professionalism or competence of our services, or the mental or physical capacity of any of our professional staff, we would ask you to discuss those concerns with us. However, if we cannot satisfy your concerns, you are entitled to file a complaint with any of the regulatory boards of the individual practitioner(s). For example, if you have a complaint concerning one of our naturopathic doctors, you can contact the College of Naturopathic Doctors of Alberta (call 403-266-2446 or at www.cnda.net).